DRAFT Minutes from the Dental Advisory Committee (DAC) Meeting
DMAS 1:00 – 3:00 PM
September 29, 2004

Members Present:	Members Absent
Mr. Chuck Duvall	Dr. Joe Paget
Dr. Fred Hamer	Dr. Vicki Tibbs
Dr. Ivan Schiff	Dr. John Unkel
Dr. Randy Adams	Dr. Girish Banaji
Dr. Zachary Hairston	Dr. Cynthia Southern
Dr. John Unkel	Dr. Ann McDonald
Dr. Tegwyn Brickhouse	Dr. Tom Spillers
Dr. Kristine Enright	Dr. Linda Bohannon
Mr. Neal Graham	Dr. Terry Dickinson
Dr. Carl Atkins	
Dr. Frank Farrington	
Dr. Neil Morrison	
Dr. Ann McDonald	

DMAS staff Present:
Pat Finnerty
Cheryl Roberts
Bryan Tomlinson
Tom Edicola
Tammy Driscoll
Dr. Steve Riggs
Maryanne Paccione
Adrienne Fegans
Sally Rice

Mr. Finnerty opened the meeting by welcoming both old and new DAC members. Introductions of all members were made. Mr. Finnerty explained that the DAC was expanded to make it more representative of the children we serve and of the providers of service.

Minutes from the April 30, 2004 DAC meeting were approved.

DAC Background

Mr. Finnerty provided a background of the DAC stating that it was formed to provide insight into the Medicaid and FAMIS programs and to help the agency identify issues and to respond to them. The goal of the DAC is to improve access to dental care for children, which is something very important to him, to Secretary Jane Woods, and to the Governor.

Mr. Finnerty stated that for years, the DAC has advocated that we change the structure of the Medicaid program and pushed for the carve-out from HMOs and to establish a single program. The DAC advocated that the program be administered in-house but, unfortunately, there were not enough resources to do this.

Mr. Finnerty gave a brief overview of a presentation that he made to the Board of the Department of Medical Assistance Services several weeks ago. The presentation was included in the packet of handouts given to committee members.

Updates

Dr. Riggs informed the DAC that DMAS is in the process of updating the dental manual to include 25 or more additional codes, including new CDT-5 codes, which will enable us to be HIPAA compliant by January 2005. These include such services as posterior 4 or more surface composite fillings, single bitewings, pulp therapy, more stainless steel crown codes, and both anesthesia codes (D9220 and D9221). He also stated that in several months, DMAS will begin accepting both the 2000 and 2002 ADA claim forms. We will use the same locators that other 3rd parties use in processing PA requests and claims, which will enable us to be as consistent with the real world as possible. We are in the testing phase now for this project.

Dr. Riggs also shared information with the DAC that DMAS is going to provide reimbursement to trained medical providers for providing fluoride varnish to children under the age of 3. This is in conjunction with the Oral Health Grant obtained by the Virginia Department of Health. Provider training is being scheduled and payment to trained providers will begin in November. Up to 6 fluoride varnish treatments will be covered and will not conflict with any fluoride treatments provided by dentists. DMAS is reimbursing the fluoride treatments under the medical portion of the contract for non-dental providers. The code used will be the same for all providers (D1203) but non-dental providers will bill this on the CMS-1500 claim form, which will distinguish it from dentists who bill on the ADA claim form.

Drs. Day and Farrington provided more details about the Oral Health Grant.

Dr. Morrison asked if a non-dental person could administer fluoride; he thought it was part of the dental license. Dr. Farrington stated that a physician can basically provide any dental service, even extractions, and that this grant has the support and approval of the Board of Dentistry.

Cheryl Roberts spoke about ED-2 (Executive Directive – 2). ED-2 is a directive issued by the Governor which formed a workgroup to be responsible for a) reviewing policies that may serve as an impediment to providing needed obstetrical care in rural areas of the Commonwealth and b) making policy recommendations as appropriate to improve access to obstetrical care in rural areas. This committee made 33 recommendations to the Governor's office. One of the recommendations applies to dentists – to expand dental coverage to pregnant women whether enrolled in Medicaid or in FAMIS.

Dr. Adams voiced a concern that there won't be enough dentists to handle the additional population. Ms. Roberts concurred and said we definitely need to increase participation in order to serve this population.

Program Structure

Ms. Roberts presented the new organizational structure of the dental program to the DAC. She explained that the DAC will be treated like any other Medicaid Board. Any major decisions will be presented to the DAC for input. This makes it very important that we always have current email addresses as things may come up that prevent us from meeting quarterly and we want to be able to communicate via email for quick turnaround on important issues.

Ms. Roberts stated that we will have some people from the DAC on the evaluation team to choose the new vendor. These must be state employees; Dr. Terry Dickinson has already appointed Dr. Farrington to be one of the members.

Two other important groups that make up the new structure of the DMAS Dental Program are the Dental Access Review Team (DART) and the Dental Implementation Advisory Group (DIAG). The DART is an internal DMAS team and the DIAG will have 3 members of the DAC as well as representatives from the MCOs and other advocates. The DIAG will handle the details of the transition. Ms. Roberts asked for 3 volunteers from the DAC to serve as members.

DMAS has established an email address, which can be used for any issues relating to dental; it is checked daily and Ms. Roberts encouraged providers to use it and to have their colleagues use it. The email address is: dental@dmas.virginia.gov.

Ms. Roberts also stated that this is the last DAC meeting where we will have FFS and MCO updates. Everything is merging into the new Medicaid Dental Program. There is currently a naming contest by DMAS staff to come up with a name for the new program.

Policy/Coverage Issues

Tammy Driscoll, the new DMAS Dental Manager, asked the DAC for input on several policy coverage issues that must be finalized for inclusion into the RFP. The first issue involves fine-tuning the services to be included by the vendor in the dental contract. (A handout was provided showing proposed covered services – some new codes are included but no CDT-5 codes). The second issue concerns defining which services should be considered "medical" vs. "dental". There are dental services rendered as a result of an accident, and medically necessary dental services (i.e. cleft palate repair, orthognathic and TMJ surgery, etc).

Dr. Atkins' opinion was that dentists do not have medical forms; dentists need to file dental forms only. Dr. Unkel asked if it could be done either way for some services. Ms. Driscoll voiced concern that we may be paying for services twice if we allow this much flexibility in billing. We want to avoid duplication of payment.

Dr. Riggs stated that DMAS FFS now tries to crosswalk the medical surgical codes to the dental codes for reimbursement. However, the one-to-one crosswalk is not always possible.

There is also a third issue as to the definition of services covered partially under "medical" and partially under "dental". Add i.e., outpatient facility/anesthesia related services. These are also outlined in the handout.

Ms. Roberts asked the DAC how other major carriers handle "dental" vs. "medical" services. Dr. Morrison stated that with Anthem, anesthesia and x-ray services (medically necessary or as a result of an accident) are considered medical but services such as impacted teeth are covered under dental. Every carrier has its own nuances. Sometimes it is easier to get an authorization under medical rather than dental according to Dr. Morrison. Dr. Atkins responded that we are asking the wrong group how other carriers handle this; that we should be asking the billing office staff. It was decided that this was a very good idea and that DMAS will email the coverage issue questions to the DAC by October 1 so that they can share them with their office staff and respond to us by October 8.

Provider Survey

Bryan Tomlinson presented a Provider Survey to the DAC. (Included in the dental packet). This survey is going to be sent to both enrolled and non-enrolled providers with the purpose of finding out what issues are causing problems and what issues are keeping providers from participating in the Medicaid program. Part of the survey was excerpted from the Univ. of Iowa's School of Dentistry. It takes about 4 minutes to complete. Mr. Tomlinson asked for feedback and received the following comments:

Dr. Farrington asked what are we trying to ascertain in #4. Are we assuming that we are moving to a single vendor program? He suggested we put #5 before #4.

Dr. Brickhouse suggested that we add a question asking dentists if they would be willing to see more Medicaid patients. It would help to have a box that says, "Yes, I am seeing Medicaid patients and would like to see more".

Dr. Morrison said that in talking to dentists, fees do not seem to be the main problem, most have just had one bad experience and that is the barrier to participation. Dr. Adams asked if we had talked to other states to find out what they have done to increase participation. Mr. Finnerty responded that other than fee increases and simplifying the administrative burden on providers, there really is no silver bullet; it's a combination of things.

Dr. Enright suggested that we make the survey a positive thing and have the dentists articulate the one thing that would make them become a Medicaid provider.

Dr Hairston observed that it's harder to re-gain a provider who has left rather than sign up a new provider.

It was suggested that we add something at the beginning of the survey to indicate whether the responder is currently a provider, has never been a provider, or used to be a provider.

We will make some revisions to the survey based on the comments received today and send it out by 10/1 asking for comments back by 10/8.

RFP

Ms. Roberts discussed the RFP. It is in early draft stage now but once Mr. Finnerty has completed reviewing it, we will send it out to the DAC and give them time to comment. We will also put the RFP on the DMAS website to allow anyone to provide feedback.

Ms. Roberts stated that now is the time to add specific requests such as "the vendor will not require…." The only caveat to this is that these requests must be economically sound. If they are cost prohibitive, we can't include them.

Mr. Graham asked if it would be possible to indicate in the RFP draft which things we have control over and can change and which things are boilerplate and have to stay in. Ms. Roberts stated that we will eliminate the "must have by state law" verbiage before sending it out to the DAC.

Ms. Roberts said that we anticipate that a "slimmer, trimmer" RFP will be ready to go out to the DAC for comments by mid-October.

Other Issues

Dr. Morrison asked a general question about how Virginia Medicaid can set their own policies for what services are covered. Mr. Finnerty explained that Medicaid is part Federal and part State and that states can set eligibility levels and can decide which services they will cover. Virginia Eligibility levels are low. We are restrictive compared to the rest of the country in what services are covered. Our eligibility levels are at the Federal minimum amount.

Prior to adjourning the meeting, Mr. Finnerty asked for input from the DAC as to what he should be saying to the dentists at the upcoming component meetings. What would be useful to hear?

Dr. Morrison said that he should stress that if everyone chipped in and agreed to provide services, it wouldn't burden the other providers as much. When everyone doesn't chip in, it puts the burden on a set few and burns out those people. It is important to ask everyone to share in the burden.

Dr. Hamer suggested building on the "Take 5" principle. If we can't pay more, at least make things less burdensome.

Dr. Atkins suggested that Mr. Finnerty acknowledge that money is an issue and that what we are paying dentists covers just their overhead; it's really a donation of time for the dentists. Dr. Enright added, however, having said this, let the dentists know that at least they can perform services in their own office with their own equipment and their own staff. It is not like other charity projects (such as MOM) where they are working with everything unfamiliar.

Dr. Hairston suggested asking the dentists to commit to a certain number of days per month to see Medicaid patients.

The discussion then turned to "no shows". Dr. Schiff stated that there are 11 doctors in his practice and that the younger partners are wanting to resign from Medicaid – they say the patients are abusive and there are too many no shows. Dr. Adams commented that he really doesn't have a problem with no shows.

Mr. Finnerty reminded the DAC that we have a letter we can send to recipients who are chronic "no shows". In the RFP, we will require that the vendor do this.

Dr. Day suggested that in addition to handling no shows, that we have the vendor do outreach – send a card with information for the parents introducing them to the new Medicaid Program, and have the new vendor emphasize that patients must keep their appointments, etc. It was agreed that this could all be built into the RFP.

Dr. Atkins stated that Healthkeepers Plus has no referral network in Richmond for oral surgery or endodontics. Ms. Driscoll will look into this.

Dr. Morrison asked a question about the MAP-122 process for non-covered services and how it appears to be a dis-incentive for providers to participate because non-enrolled providers are receiving their full fee (Medicaid allowance plus Patient Pay) but enrolled providers have to accept the Medicaid allowance as payment in full. Ms. Driscoll said she would follow-up to see if this is correct.

The meeting ended at 3:10 p.m.